

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9022

Item 12 Film G269 8-22-60 et

CERTIFICATE OF DEATH

08996

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY N.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 1 month	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lempi Middle Last Aitto		4. DATE OF DEATH Month 8 Day 11 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1899
9. AGE (In years lost birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Finland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gustav Kiikka		14. MOTHER'S MAIDEN NAME No record	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT George Aitto Elkton, Md. RD#1 Box 260	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA, head, pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/7 , 19 60 to 8/11 , 19 60 that I last saw the deceased alive on 8/10 1960 , and that death occurred at 600 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE John A. Fischer		ADDRESS (Street, city or town, state) 162 W MAIN ST. ELKTON, MD	
PHYSICIAN'S NAME (Type) John A. Fischer		DATE SIGNED 8/11/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation Aug. 15, 1960		22b. DATE THEREOF Aug. 15, 1960	
22c. NAME OF CEMETERY OR CREMATORY Silverbrook		22d. LOCATION (City, town, or county) (State) Wilmington, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE R.T. Jones		ADDRESS Newark, Del.	
24a. REC'D BY REGISTRAR DATE AUG 16 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO DEPUTY MEDICAL EXAMINER: Certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
9042 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rising Sun, Colora		c. LENGTH OF STAY IN lb several yrs.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.		b. COUNTY Cecil		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Colora		d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Alt		First		Middle		Last		4. DATE OF DEATH 8 30 19 60		Month		Day		Year	
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-25-1930		9. AGE (In years last birthday) 28 29 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Pony Farm		11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Arthur J. Alt		14. MOTHER'S MAIDEN NAME Mabel Lindsay													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes Jan. 1951 - Jan. 1952		16. SOCIAL SECURITY NO. 393-28-9402		17. INFORMANT Mrs. William Alt. Rising Sun, Md.		Address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rifle shot in left breast DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Placed rifle against chair and chest and hit trigger with stick		INTERVAL BETWEEN ONSET AND DEATH													
20c. TIME OF INJURY 8:45 a.m. 8 30 19 60		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm		20f. (City or town) Colora		(County) Cecil		(State) Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8-30-60							
ACTUAL SIGNATURE R.C. Dodson		EXAMINER'S NAME (Type) R.C. Dodson		M.D.		Address (Street, city, town, or county) West Nottingham									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 3 1960		22c. NAME OF CEMETERY OR CREMATORY West Nottingham		22d. LOCATION (City, town, or country) Near Colora, Md.									
23. FUNERAL DIRECTOR William P. Johnston		ADDRESS Offord Pa.		24a. REC'D BY REGISTRAR SEP 2 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus									

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OF NEW YORK

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9043 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08998

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newark, R.D. 12		c. LENGTH OF STAY IN 1b 46 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newark R.D. 2	
3. NAME OF DECEASED (Type or print) Benjamin Franklin Badders		4. DATE OF DEATH Month 8 Day 10 Year 19 60	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-11-1876
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Badders		14. MOTHER'S MAIDEN NAME Elizabeth Moore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mrs. Benjamin F. Badders, New Ark, Del. R.D. 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: 592X IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Chronic Nephritis (c) Chronic Nephritis DUE TO (c) Chronic Nephritis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8-11-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/13/60	
22c. NAME OF CEMETERY OR CREMATORY Head of Christiana Cem.		22d. LOCATION (City, town, or county) (State) Newark Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE Albert J. McCrery		24a. REC'D BY REGISTRAR Albert J. McCrery	
24b. REGISTRAR'S SIGNATURE Albert J. McCrery		24c. ADDRESS 2700 Washington St., Wilmington, Delaware	
24d. DATE Aug 16 '60		24e. REGISTRAR'S SIGNATURE Albert J. McCrery	

21.

S. M. J. ...

25. 1. 1970

020

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

THE UNIVERSITY OF CHICAGO

1990

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03000

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1. PLACE OF DEATH a. COUNTY Cecil <div style="text-align: right;">MARYLAND</div>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point,			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital				d. STREET ADDRESS 4713 Fairfield Drive			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Joseph Middle J. Last Cunningham				4. DATE OF DEATH Month 8 Day 20 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-4-16		9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) S. Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph John Cunningham				14. MOTHER'S MAIDEN NAME Stella Roberts			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-11		17. INFORMANT Iann Cunningham, wife, 7224 Lee Street. Address Columbia, S. C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mutilated Body Resulting From Being Hit By Train. Immed. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 979X (b) _____ DUE TO (c) _____ </div> <div style="width: 65%;"> INTERVAL BETWEEN ONSET AND DEATH Immed. </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year 3:50 P.M. 8 20 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) PRR Tracks		20f. (City or town) (County) (State) Perryville Cecil, Maryland	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>R.C. Dodson</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) R.C. DODSON				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		8-20-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) 8/25/60		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Pennington & Son</i>				ADDRESS Hayre de Grace, Md.		24a. REC'D BY REGISTRAR DATE AUG 31 '60	
				24b. REGISTRAR'S SIGNATURE <i>Clifton L. K...</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1004

Name of Deceased		John J. Lunn	
Sex		Male	
Age		25-34	
Date of Birth		1900-10-10	
Place of Birth		Baltimore, Md.	
Occupation		Carpenter	
Cause of Death		Heart Disease	
Manner of Death		Natural	
Signature of Medical Examiner		<i>[Signature]</i>	
Date of Examination		1925-10-15	
Place of Examination		Home	
Signature of Coroner		<i>[Signature]</i>	
Date of Issuance		1925-10-15	
Place of Issuance		Baltimore, Md.	

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(R.D.)

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒

Year

Davis

IF UNDER 24 HRS.

Hours	Min
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12. CITIZEN OF WHAT COUNTRY?

U.S.A

Elizabeth George

Address _____

Alice Marie Husefelt Childs 1946

INTERVAL BETWEEN ONSET AND DEATH

NSET AND DEATH

(c)

8 mos.

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)

(State)

ADDRESS (Street, city or town, state)

123 Single Ave

Elkton Md

22d LOCATION (City, town, or county) (State)

24b. REGISTRAR'S SIGNATURE

Elkton, Maryland

Carlton S. Kraus

VS A1S (4)
1SM 9/5B

10001

CENTRE EAST OF DEATH

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(10001)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9045

Item 7 Film 6269 8-25-60 et

09002

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Unknown	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle M. Last DAVIS		4. DATE OF DEATH Month August Day 9 Year 19 60	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-15-95
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 65 Days 65 Hours 65 Min. 65	IF UNDER 24 HRS. Months 65 Days 65 Hours 65 Min. 65
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farmer	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James F. Davis	
14. MOTHER'S MAIDEN NAME Bell Redd		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I	
16. SOCIAL SECURITY NO. 222-03-3668		17. INFORMANT Harry N. Davis, brother, 5820 Addison St., Philadelphia, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia right lower lobe DUE TO 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the stomach with widespread metastasis to abdominal cavity DUE TO 3:15pm (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 10 (this hospital) attended the deceased from August 6 1960 to August 9 1960 and that death occurred at 3:15pm on the causes and on the date stated above.			
22a. SIGNATURE J. L. Garey		22b. DATE SIGNED 8-10-60	
22c. PHYSICIAN'S NAME (Type) J. L. GAREY, Clinical Pathologist,		22d. ADDRESS V.A. Hospital, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 13, 1960	
23c. NAME OF CEMETERY OR CREMATORY Unknown		23d. LOCATION (City, town, or county) (State) Cecilton, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Cecilton, Maryland		25a. REC'D BY REGISTRAR AUG 15 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1

9025

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09003

Item 1 Film G269 8-18-60 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 9yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) -----		d. STREET ADDRESS Elkton, R.D.# 1	
3. NAME OF DECEASED (Type or print) A. Clark C. Dutton		4. DATE OF DEATH Month August Day 8 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1, 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Textile		9. AGE (In years last birthday) 66 yrs.	11. BIRTHPLACE (State or foreign country) Delaware
10b. KIND OF BUSINESS OR INDUSTRY Textile		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Dutton		14. MOTHER'S MAIDEN NAME Arabella Prettyman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 221-07-3396	
17. INFORMANT Address Preston E. Dutton, Claymont, Del.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis (c) Arteriosclerosis DUE TO (c) Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Ralph E. Hickman M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Ralph E. Hickman		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-11-60	22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cem.	22d. LOCATION (City, town, or county) (State) Elkton, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ralph E. Hickman, Elkton, Md		24a. REC'D BY REGISTRAR DATE AUG 12 '60	24b. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

10000

CERTIFICATE OF DEATH

Blank form with horizontal lines for text entry.

10000

Vertical text on the right margin, possibly a date or file number.

9027

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 1 mo. 14 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS Main St.			
3. NAME OF DECEASED (Type or print) First William Middle Chester Last Harvey				4. DATE OF DEATH Month August Day 14 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 2, 1880		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter (ret.)		10b. KIND OF BUSINESS OR INDUSTRY Veterans Administration		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Harvey				14. MOTHER'S MAIDEN NAME Elizabeth A. Friday			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 212-01-5073		INFORMANT Mrs. Allie M. Harvey, North East, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Prostate						INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. — 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/25, 1960, to 8/14, 1960, that I last saw the deceased alive on 8/14, 1960, and that death occurred at 7:45 AM from the causes and on the date stated above.							
ACTUAL SIGNATURE Klaus H. Huebner				ADDRESS (Street, city or town, state) North East, Md.			
PHYSICIAN'S NAME (Type) Klaus H. Huebner M.D.				DATE SIGNED 8/14/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-17-60		22c. NAME OF CEMETERY OR CREMATORY North East Methodist Cem.		22d. LOCATION (City, town, or county) (State) North East Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant				24a. REC'D BY REGISTRAR DATE AUG 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9028

CERTIFICATE OF DEATH

09006

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 18 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Cecil		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Charles Middle P Last Holden		4. DATE OF DEATH Month August Day 21 Year 1960		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 6, 1878		9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours		11. IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (ret.)		10b. KIND OF BUSINESS OR INDUSTRY Farming Farm Owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William W. Holden		14. MOTHER'S MAIDEN NAME Talitha Mahoney		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-36-8733		INFORMANT Mr. George Holden, Address North East, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, right lower lobe 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 month		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular disease and emphysema		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 27, 1960, at 4 P, that I last saw the deceased alive on August 21, 1960, and that death occurred at 4 P, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 233 E. Main Street		DATE SIGNED 8/21/60		ACTUAL SIGNATURE S. Ralph Andrews, Jr., M.D.		PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.		Elkton, Maryland		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-24-60		22c. NAME OF CEMETERY OR CREMATORY North East Methodist Cem.		22d. LOCATION (City, town, or county) (State) North East Cecil Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant		ADDRESS North East, Maryland.		24a. REC'D BY REGISTRAR DATE AUG 30 1960		24b. REGISTRAR'S SIGNATURE Arthur S. Evans													

MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH

0084

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 9029
 CERTIFICATE OF DEATH

09007

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 13 Hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle STEPHEN Last HOTRA				4. DATE OF DEATH Month Aug. Day 15 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1960		9. AGE (In years last birthday) yrs. 13	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Hotra				14. MOTHER'S MAIDEN NAME Mildred Maksyn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		INFORMANT Address Mr. John Hotra, Chesapeake City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 760.5 IMMEDIATE CAUSE (a) Alveolar lung hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Inter cerebral hemorrhage - Prematurity						INTERVAL BETWEEN ONSET AND DEATH few hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 15, 1960 to Aug. 15, 1960 , that I last saw the deceased alive on Aug. 15, 1960 , and that death occurred at 8:15 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Henry V. Davis M.D.				ADDRESS (Street, city or town, state) CHESAPEAKE CITY MD DATE SIGNED 8/16/60			
PHYSICIAN'S NAME (Type) HENRY V. DAVIS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-17-60		22c. NAME OF CEMETERY OR CREMATORY St. Roses Cemetery		22d. LOCATION (City, town, or county) (State) Chesapeake City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME				ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR AUG 23 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Huns			

UNITED STATES OF AMERICA

2023

Case

MD

Case

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John Doe

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

Item 9 FilmG270 9-6-60 et
9030
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

09008

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EIKTON		c. LENGTH OF STAY IN 1b 9 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS Rd #1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Howell		4. DATE OF DEATH Month Day Year Aug. 25 19 60	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/16/1885
9. AGE (In years lost birthday) 75 1/2 yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mines	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Howell		14. MOTHER'S MAIDEN NAME Minnie Carter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Inez S. Trent Rd #1 EIKTON, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X Anemia Mal nutrition DUE TO (b) Cancer of lung & Metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 6 Mos.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1st, 19 60, to Aug 25, 19 60 that I lost sowed the deceased olive on Aug 25, 19 60, and that death occurred at 4:45 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph G. Lanz M.D.		ADDRESS (Street, city or town, state) 205 W Main St EIKTON Md	
DATE SIGNED 8/25/60			
PHYSICIAN'S NAME (Type) Joseph G. Lanz		EIKTON Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-27-60	
22c. NAME OF CEMETERY OR CREMATORY EIKTON Cemetery		22d. LOCATION (City, town, or county) (State) EIKTON Md	
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home		ADDRESS EIKTON, Md.	
24a. REC'D BY REGISTRAR DATE AUG 30 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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WILLIAM C. CROFT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9031

CERTIFICATE OF DEATH

Reg. Dist. 09009

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Devine Haven Nursing Home</u>		d. STREET ADDRESS <u>399 W. Main St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clara B. Hutchins</u>		4. DATE OF DEATH Month Day Year <u>Aug. 27 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 3, 1867</u>
9. AGE (In years last birthday) <u>93</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elias James</u>		14. MOTHER'S MAIDEN NAME <u>SINAH Jester</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>222-07-6872</u>	
17. INFORMANT Address <u>Mrs. Nolan Hutchins, ELKTON Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cerebrovascular accident with hemiplegia</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic cardiovascular disease; hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 16</u> , 19 <u>60</u> , to <u>Aug. 27</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Aug. 27</u> , 19 <u>60</u> , and that death occurred at <u>10:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		ADDRESS (Street, city or town, state) <u>233 E. Main Street</u> DATE SIGNED <u>8/27/60</u>	
PHYSICIAN'S NAME (Type) <u>S. RALPH ANDREWS, JR., M.D.</u>		<u>Elkton, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/30/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lake Side Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Dover Del.</u>
23. FUNERAL/DIRECTOR'S SIGNATURE <u>H. Walter du Bose, Jr.</u> ADDRESS <u>ELKTON, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 30 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9032 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **09010**

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, Md.		c. LENGTH OF STAY IN 1b 4 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, Md. R.D. #1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				d. STREET ADDRESS R.D. #1			
3. NAME OF DECEASED (Type or print) First Columbus Middle Lee Last Jackson				4. DATE OF DEATH Month 8/ Day 17/ Year 19 60			
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/28/1960		9. AGE (In years last birthday) yrs. 1		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Elkton, Maryland	12. CITIZEN OF WHAT COUNTRY? —		
13. FATHER'S NAME Clarence Andrew Jackson			14. MOTHER'S MAIDEN NAME Martha Lean Gill				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Address Clarence Andrew Jackson R D #1 Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dehydration and malnutrition</u> <div style="margin-top: 10px;"> 773.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) </div> </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>R. C. Dodson</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 8/17/60			
EXAMINER'S NAME (Type) R. C. Dodson DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			
22b. DATE THEREOF AUG 19 1960		22c. NAME OF CEMETERY OR CREMATORY NORTH EAST CEMETERY		22d. LOCATION (City, lawn, or county) (State) NORTH EAST, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME				24a. REC'D BY REGISTRAR AUG 23 60			
ADDRESS Donald M. De				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Huns</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. Prior to burial, cremation, or removal, file pages 1 and 2 with the registrar.

1

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9033

CERTIFICATE OF DEATH

Reg. Dist. No.

09011

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN 1b <u>2 d.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union</u>				d. STREET ADDRESS <u>1 Dickie Biddle Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>Keithley</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>23</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-1-85</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>4</u> Hours <u>1</u> Min. <u>0</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Elk Neck Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>James Keithley</u>				14. MOTHER'S MAIDEN NAME <u>Susan Heath</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>W. Robert Keithley Elkton, Md</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO <u>Decompensation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerosis, Generalized</u> DUE TO <u>years</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 mos.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April, 1960</u> to <u>Aug 23, 1960</u> , that I lost sow the deceased alive on <u>Aug 23, 1960</u> , and that death occurred at <u>4:40 P</u> M, from the causes ond on the date stoted above.							
ACTUAL SIGNATURE <u>Tillman D Johnson</u> M.D.				ADDRESS (Street, city or town, state) <u>123 Sinsley Ave</u>			
PHYSICIAN'S NAME (Type) <u>Tillman D Johnson</u>				DATE SIGNED <u>Elkton, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>8/26/60</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Elkton, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u> ADDRESS <u>Elkton, Md.</u>				24a. REC'D BY REGISTRAR <u>Aug 29 '60</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1900

CERTIFICATE OF DEATH

1900

Blank form area for recording death certificate details.

9034

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 40 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton 21		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Un 430 North Street				d. STREET ADDRESS 430 North Street			
3. NAME OF DECEASED (Type or print) First Middle Last James W. Kincaid				4. DATE OF DEATH Month Day Year 8 14 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 15, 1894		9. AGE (In years lost birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Lineman		10b. KIND OF BUSINESS OR INDUSTRY Conowingo Power Company		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas J. Kincaid				14. MOTHER'S MAIDEN NAME Mary Young			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 217-01-8062		INFORMANT Address William P. Kincaid, Elkton, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 CORONARY OCCLUSION DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STOLING THE UNDER-lying cause lost. INTERVAL BETWEEN ONSET AND DEATH 1 hr 9 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hemorrhage, Secondary To duodenal ulcer.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/14/60 to 8/14/60, that I last saw the deceased alive on 8/14/60, and that death occurred at 2:00 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John A. Fischer				ADDRESS (Street, city or town, state) DATE SIGNED 162 W MAIN ST. 8/16/60			
PHYSICIAN'S NAME (Type) John A. Fischer				ELKTON, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/17/60		22c. NAME OF CEMETERY OR CREMATORY Immaculate Conception		22d. LOCATION (City, town, or county) (State) Elkton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks				ADDRESS Elkton, Maryland		24a. REC'D BY REGISTRAR DATE AUG 18 '60	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kincaid	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09013

9046

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Pa. b. COUNTY Bucks			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City, R.D. Visting				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lititz R.D.1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 75X-3			
3. NAME OF DECEASED (Type or print) First Charles Middle L Last Lehr				4. DATE OF DEATH Month 8 Day 7 Year 19 60			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-21-1915		9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Station		10b. KIND OF BUSINESS OR INDUSTRY Sales		11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Purman Lehr				14. MOTHER'S MAIDEN NAME Hattie Kutz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW 2 196-05-6081		17. INFORMANT Mrs. Charles L Lehr, Lititz, R.D.1, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowned DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 929.8 DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drowned trying to rescue another man					
20c. TIME OF INJURY Month, Day, Year 8 7 60 Hour, a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Elk River		20f. (City or town) (County) (State) Port Herman Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8-7-60	
EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 10, 1960		22c. NAME OF CEMETERY OR CREMATORY Mellingers Cemetery		22d. LOCATION (City, town, or county) (State) Schoeneck, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME				ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR AUG 11 1960	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

000013

10-1-6

10

1. Name of deceased JAMES J. HANCOCK		2. Date of death 10-1-6	
3. Age 45		4. Sex Male	
5. Race White		6. Marital status Married	
7. Usual residence 123 Main St., Boston, Mass.		8. Cause of death Heart disease	
9. Manner of death Natural		10. Signature of medical examiner J. J. Smith	
11. Signature of coroner J. J. Smith		12. Signature of registrar J. J. Smith	
13. Signature of physician J. J. Smith		14. Signature of funeral director J. J. Smith	
15. Signature of undertaker J. J. Smith		16. Signature of cemetery J. J. Smith	
17. Signature of burial place J. J. Smith		18. Signature of interment J. J. Smith	
19. Signature of burial place J. J. Smith		20. Signature of interment J. J. Smith	
21. Signature of burial place J. J. Smith		22. Signature of interment J. J. Smith	
23. Signature of burial place J. J. Smith		24. Signature of interment J. J. Smith	
25. Signature of burial place J. J. Smith		26. Signature of interment J. J. Smith	
27. Signature of burial place J. J. Smith		28. Signature of interment J. J. Smith	
29. Signature of burial place J. J. Smith		30. Signature of interment J. J. Smith	
31. Signature of burial place J. J. Smith		32. Signature of interment J. J. Smith	
33. Signature of burial place J. J. Smith		34. Signature of interment J. J. Smith	
35. Signature of burial place J. J. Smith		36. Signature of interment J. J. Smith	
37. Signature of burial place J. J. Smith		38. Signature of interment J. J. Smith	
39. Signature of burial place J. J. Smith		40. Signature of interment J. J. Smith	
41. Signature of burial place J. J. Smith		42. Signature of interment J. J. Smith	
43. Signature of burial place J. J. Smith		44. Signature of interment J. J. Smith	
45. Signature of burial place J. J. Smith		46. Signature of interment J. J. Smith	
47. Signature of burial place J. J. Smith		48. Signature of interment J. J. Smith	
49. Signature of burial place J. J. Smith		50. Signature of interment J. J. Smith	
51. Signature of burial place J. J. Smith		52. Signature of interment J. J. Smith	
53. Signature of burial place J. J. Smith		54. Signature of interment J. J. Smith	
55. Signature of burial place J. J. Smith		56. Signature of interment J. J. Smith	
57. Signature of burial place J. J. Smith		58. Signature of interment J. J. Smith	
59. Signature of burial place J. J. Smith		60. Signature of interment J. J. Smith	
61. Signature of burial place J. J. Smith		62. Signature of interment J. J. Smith	
63. Signature of burial place J. J. Smith		64. Signature of interment J. J. Smith	
65. Signature of burial place J. J. Smith		66. Signature of interment J. J. Smith	
67. Signature of burial place J. J. Smith		68. Signature of interment J. J. Smith	
69. Signature of burial place J. J. Smith		70. Signature of interment J. J. Smith	
71. Signature of burial place J. J. Smith		72. Signature of interment J. J. Smith	
73. Signature of burial place J. J. Smith		74. Signature of interment J. J. Smith	
75. Signature of burial place J. J. Smith		76. Signature of interment J. J. Smith	
77. Signature of burial place J. J. Smith		78. Signature of interment J. J. Smith	
79. Signature of burial place J. J. Smith		80. Signature of interment J. J. Smith	
81. Signature of burial place J. J. Smith		82. Signature of interment J. J. Smith	
83. Signature of burial place J. J. Smith		84. Signature of interment J. J. Smith	
85. Signature of burial place J. J. Smith		86. Signature of interment J. J. Smith	
87. Signature of burial place J. J. Smith		88. Signature of interment J. J. Smith	
89. Signature of burial place J. J. Smith		90. Signature of interment J. J. Smith	
91. Signature of burial place J. J. Smith		92. Signature of interment J. J. Smith	
93. Signature of burial place J. J. Smith		94. Signature of interment J. J. Smith	
95. Signature of burial place J. J. Smith		96. Signature of interment J. J. Smith	
97. Signature of burial place J. J. Smith		98. Signature of interment J. J. Smith	
99. Signature of burial place J. J. Smith		100. Signature of interment J. J. Smith	

10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9035

CERTIFICATE OF DEATH

Reg. Dist. No. 09014

1. PLACE OF DEATH o. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. LENGTH OF STAY IN 1b 5 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ELKTON NURSING HOME		d. STREET ADDRESS R.D. # 2	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First REBECCA Middle JANE Last MACKLEM		4. DATE OF DEATH Month AUG Day 11 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 MAY 1872
9. AGE (In years lost birthday) 88 yrs.		IF UNDER 1 YEAR Months 11 Days 11 Hours 11 Min.	IF UNDER 24 HRS. Hours 11 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMER	11. BIRTHPLACE (State or foreign country) DEL
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN M. MACKLEM		14. MOTHER'S MAIDEN NAME ELIZABETH DAVIES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. 217-36-4983	
17. INFORMANT Miss Sarah L. Macklem		Address Harford Rd. #2 MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heartache DUE TO (b) Greenly's arteriosclerosis DUE TO (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH 11 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 4, 1960 to August 11, 1960 , that I last saw the deceased alive on August 11, 1960 , and that death occurred at 11:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Ralph Andrews, Jr.		ADDRESS (Street, city or town, state) 233 E. Main St. Elkton, Maryland	
PHYSICIAN'S NAME (Type) S. RALPH ANDREWS JR.		DATE SIGNED Aug 11, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 14 AUG. 1960	
22c. NAME OF CEMETERY OR CREMATORY Rock Rock Cem.		22d. LOCATION (City, town, or county) (State) HARFORD E. MD	
23. FUNERAL DIRECTOR'S SIGNATURE H. Madison Mitchell		ADDRESS 123 S. Washington	
DATE AUG 15 '60		24b. REGISTRAR'S SIGNATURE Charles S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

2003

CERTIFICATE OF DEATH

1000

(1)

[Faint, illegible text, likely bleed-through from the reverse side of the page]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9036

CERTIFICATE OF DEATH

Reg. Dist. No. 09015

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Gertrude Middle Manlove Last Manlove				4. DATE OF DEATH Month August Day 14 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 29, 1898	
9. AGE (In years last birthday) yrs. 62		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Teaching		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME John L. Manlove			
14. MOTHER'S MAIDEN NAME Mary Anderson				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO.				17. INFORMANT Mrs. Clara Burke, Address Cecilton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left hemiplegia 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intra-cranial hemorrhage DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 10, 1933 , to August 14, 1960 , that I last saw the deceased alive on Aug 14, 1960 , and that death occurred at 3:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Henry H. Davis M.D.				DATE SIGNED 8/15/60			
PHYSICIAN'S NAME (Type) HENRY H. DAVIS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 17, 1960		22c. NAME OF CEMETERY OR CREMATORY Cecilton Cemetery		22d. LOCATION (City, town, or county) (State) Cecilton Cecil Co; Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Mellington, Md.				24a. REC'D BY REGISTRAR DATE AUG 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

100-10000

CERTIFICATE OF DEATH

100-10000

STATE OF MARYLAND DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
JAN 1 1900		AT HOME		NATURAL	
TIME OF DEATH		AGE		SEX	
10:00 AM		60 YEARS		MALE	
HOURS		MINUTES		SECONDS	
10		00		00	
DATE OF BIRTH		PLACE OF BIRTH		MANNER OF BIRTH	
JAN 1 1840		AT HOME		NATURAL	
TIME OF BIRTH		AGE		SEX	
10:00 AM		60 YEARS		MALE	
HOURS		MINUTES		SECONDS	
10		00		00	
DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
JAN 1 1900		AT HOME		NATURAL	
TIME OF DEATH		AGE		SEX	
10:00 AM		60 YEARS		MALE	
HOURS		MINUTES		SECONDS	
10		00		00	
DATE OF BIRTH		PLACE OF BIRTH		MANNER OF BIRTH	
JAN 1 1840		AT HOME		NATURAL	
TIME OF BIRTH		AGE		SEX	
10:00 AM		60 YEARS		MALE	
HOURS		MINUTES		SECONDS	
10		00		00	

100-10000

STATE OF MARYLAND DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09016

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East, R.D.		c. LENGTH OF STAY IN 1b —	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Arthur Middle Maus Last		4. DATE OF DEATH Month 8 Day 2 Year 19 60	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-3-1910
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Projection Op. Equip		10b. KIND OF BUSINESS OR INDUSTRY V.A. Administration	
11. BIRTHPLACE (State or foreign country) New York,		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Phillip M		14. MOTHER'S MAIDEN NAME Ida Ziesig	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	
17. INFORMANT V.A. Administration, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mutilated Body DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Squatted xdown on P.R.R. Tracks in front of train	
20c. TIME OF INJURY Month, Day, Year 10:40 a.m. 8 2 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) P.R.R. Tracks		20f. (City or town) (County) (State) North East, R.D. Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R.C. Dodson		DATE SIGNED 8-3-60	
EXAMINER'S NAME (Type) R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-4-1960	22c. NAME OF CEMETERY OR CREMATORY Hopewell Methodist	22d. LOCATION (City, town, or county) (State) Port Deposit Cecil Md
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R Grant		24a. REC'D BY REGISTRAR Aug 5 '60	
ADDRESS North East Md		24b. REGISTRAR'S SIGNATURE Arthur S. Thues	

MEDICAL CERTIFICATION

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Race		4. Date of Birth		5. Date of Death	
J. J. J. J. J.		M		W		J. J. J. J. J.		J. J. J. J. J.	
6. Usual Residence		7. Place of Death		8. Cause of Death		9. Manner of Death		10. Signature of Medical Examiner	
J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.	
11. Signature of Coroner		12. Signature of Physician		13. Signature of Medical Examiner		14. Signature of Registrar		15. Signature of Clerk	
J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.	
16. Signature of Medical Examiner		17. Signature of Registrar		18. Signature of Clerk		19. Signature of Medical Examiner		20. Signature of Registrar	
J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.	
21. Signature of Medical Examiner		22. Signature of Registrar		23. Signature of Clerk		24. Signature of Medical Examiner		25. Signature of Registrar	
J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.	
26. Signature of Medical Examiner		27. Signature of Registrar		28. Signature of Clerk		29. Signature of Medical Examiner		30. Signature of Registrar	
J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.	
31. Signature of Medical Examiner		32. Signature of Registrar		33. Signature of Clerk		34. Signature of Medical Examiner		35. Signature of Registrar	
J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.	
36. Signature of Medical Examiner		37. Signature of Registrar		38. Signature of Clerk		39. Signature of Medical Examiner		40. Signature of Registrar	
J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.	
41. Signature of Medical Examiner		42. Signature of Registrar		43. Signature of Clerk		44. Signature of Medical Examiner		45. Signature of Registrar	
J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.	
46. Signature of Medical Examiner		47. Signature of Registrar		48. Signature of Clerk		49. Signature of Medical Examiner		50. Signature of Registrar	
J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.	
51. Signature of Medical Examiner		52. Signature of Registrar		53. Signature of Clerk		54. Signature of Medical Examiner		55. Signature of Registrar	
J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.	
56. Signature of Medical Examiner		57. Signature of Registrar		58. Signature of Clerk		59. Signature of Medical Examiner		60. Signature of Registrar	
J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.	
61. Signature of Medical Examiner		62. Signature of Registrar		63. Signature of Clerk		64. Signature of Medical Examiner		65. Signature of Registrar	
J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.	
66. Signature of Medical Examiner		67. Signature of Registrar		68. Signature of Clerk		69. Signature of Medical Examiner		70. Signature of Registrar	
J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.	
71. Signature of Medical Examiner		72. Signature of Registrar		73. Signature of Clerk		74. Signature of Medical Examiner		75. Signature of Registrar	
J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.	
76. Signature of Medical Examiner		77. Signature of Registrar		78. Signature of Clerk		79. Signature of Medical Examiner		80. Signature of Registrar	
J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.	
81. Signature of Medical Examiner		82. Signature of Registrar		83. Signature of Clerk		84. Signature of Medical Examiner		85. Signature of Registrar	
J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.	
86. Signature of Medical Examiner		87. Signature of Registrar		88. Signature of Clerk		89. Signature of Medical Examiner		90. Signature of Registrar	
J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.	
91. Signature of Medical Examiner		92. Signature of Registrar		93. Signature of Clerk		94. Signature of Medical Examiner		95. Signature of Registrar	
J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.	
96. Signature of Medical Examiner		97. Signature of Registrar		98. Signature of Clerk		99. Signature of Medical Examiner		100. Signature of Registrar	
J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.		J. J. J. J. J.	

9037

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09017

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b 15 yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, R.D. 5	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James Charles Maxwell				4. DATE OF DEATH Month Day Year August 1, 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 29, 1909	
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver			10b. KIND OF BUSINESS OR INDUSTRY Chemical		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Henry Maxwell				14. MOTHER'S MAIDEN NAME Mary Sayers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes W W 2				16. SOCIAL SECURITY NO. 229-01-60435		17. INFORMANT Mrs. Rhoda M. Maxwell, Elkton, Md. Address R.D. 5	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction due to DUE TO (c) Massive coronary thrombosis 14 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 1 hr.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-19 1960 to 8-1 1960, that (I) (we) lost the deceased alive on 8-30 1960, and that death occurred at 2 AM, from the causes and on the date stated above.							
22a. SIGNATURE G. H. Richards, Jr.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/3/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 8/4/60		23c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Memorial Park, Elkton, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Nicks				ADDRESS Elkton, Md.		25a. REC'D BY REGISTRAR DATE AUG 8 '60	
						25b. REGISTRAR'S SIGNATURE Arthur S. Huns	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09013

CERTIFICATE OF DEATH

09013

(1)

(1)



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09018

Reg. Dist. No.

9048

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlestown</u>			c. LENGTH OF STAY IN 1b 	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural, R. D. 1</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sea Mark Marino</u>				e. STREET ADDRESS <u>Elkton, Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>AMOS</u> Middle <u>MULLINS</u> Last <u>MULLINS</u>				4. DATE OF DEATH Month <u>August</u> Day <u>19</u> Year <u>19 60</u>						
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 1, 1899</u>		9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Guard</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Veterans Adm. Hosp., Perry Point Maryland</u>			11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>-----</u>				14. MOTHER'S MAIDEN NAME <u>Nancy ---</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <u>W. War 2</u>		16. SOCIAL SECURITY NO. 		17. INFORMANT Address <u>Mrs. Irene Mullins, R. D. 1, Elkton, Md.</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) <u>Fell into the North East River</u>							
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>8/ 1960</u> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>North East River</u>				20f. (City or town) (County) (State) <u>Charlestown, Cecil, Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>R. D. Dodson</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED		
EXAMINER'S NAME (Type) <u>R. D. Dodson, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>August 21, 1960</u>		
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/25/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>North East Methodist Cemetery, North East, Md.</u>			22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>				ADDRESS <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 20 Film 6271 9-29-60 ams				MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				10169			
9038				CERTIFICATE OF DEATH				Reg. Dist. No.			
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)							
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		a. STATE		b. COUNTY	
Cecil		Elkton		3 weeks		Union Hospital		Maryland		Cecil	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
First		Middle		Last		Month		Day		Year	
Bessie		Denny		Pearson		August		29		1960	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct. 22, 1880		79 yrs.	Months		Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife						Maryland		U. S. A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
Frank J. Denny				Lydia A. Thomas							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		INFORMANT		Address			
No						Mr. Edwin O. Pearson, Childs, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)								AUG 28-1960			
904.0 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
								Lived alone, was found by neighbor unable to walk			
20c. TIME OF INJURY		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
Hour a. m. 8 p. m.		While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		Home		Childs		Cecil		Md	
21. I certify that I attended the deceased from Aug 29, 1960, to Aug 29, 1960, that I last saw the deceased alive on Aug 29, 1960, and that death occurred at 1:30 PM from the causes and on the date stated above.											
ACTUAL SIGNATURE				ADDRESS (Street, city or town, state)				DATE SIGNED			
HENRY V. DAVIS M.D.				Childs, Cecil, Md				8/30/60			
PHYSICIAN'S NAME (Type)											
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)	
Burial				Sept. 2, 1960		Elkton Cemetery		Elkton, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Ralph E. Hicks				Elkton, Maryland				DATE SEP 13 '60		Arthur L. Kessick	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9049

CERTIFICATE OF DEATH

09020

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) Laura First Morgan Middle Pollard Last				4. DATE OF DEATH Month Aug. Day 10 Year 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1894	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert T. Morgan				14. MOTHER'S MAIDEN NAME Mary W. Cochran			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mary E. Stipa Cecilton Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Cecum with wide spread metastasis 153.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 6 months.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 3, 1960 , 19____, to Aug 10, 1960 , 19____, that I last saw the deceased alive on Aug 10 1960 , 19____, and that death occurred on Aug 10 1960 at 2:00P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Wallace Obenshain M.D.				ADDRESS (Street, city or town, state) DATE SIGNED 12 Aug 60			
PHYSICIAN'S NAME (Type) Wallace Obenshain M.D. Cecilton, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 13, 1960		22c. NAME OF CEMETERY OR CREMATORY Galena Cemetery		22d. LOCATION (City, town, or county) (State) Galena Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward E. Mellington M.D. ADDRESS				24a. REC'D BY REGISTRAR DATE AUG 15 '60		24b. REGISTRAR'S SIGNATURE	

00630

CERTIFICATE OF DEATH

9043

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES E. HAYES		M		45		JAN 10, 1890		BALTIMORE		MD		MD		USA	
RACE		COLOR		RELIGION		EDUCATION		OCCUPATION		MARRIAGE		MILITARY SERVICE		REMARKS	
WHITE		WHITE		METHODIST		HIGH SCHOOL		LABORER		MARRIED		ARMY		DIED OF HEART DISEASE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
JAN 15, 1935		BALTIMORE		HEART DISEASE		NATURAL		JAN 15, 1935		JAMES E. HAYES		JAMES E. HAYES		JAMES E. HAYES	
TIME OF DEATH		TEMPERATURE		PULSE		RESPIRATION		BLOOD PRESSURE		URINE		FECES		OTHER	
10:00 AM		98.6		60		16		120/80		NORMAL		NORMAL		NONE	
DATE OF BURIAL		PLACE OF BURIAL		CITY OF BURIAL		STATE OF BURIAL		COUNTRY OF BURIAL		REMARKS		REMARKS		REMARKS	
JAN 16, 1935		BALTIMORE		MD		MD		USA		DIED OF HEART DISEASE		DIED OF HEART DISEASE		DIED OF HEART DISEASE	

1908

CERTIFICATE OF DEATH

2000

WILLIAM

DEATH

Silver Spring

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9051

Item 9 film 270 9-6-60 et

CERTIFICATE OF DEATH

09022

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 4mos.8days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BENJAMIN F. SINGLETON		4. DATE OF DEATH Month Day Year August 28 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-11-93
9. AGE (In years last birthday) 66 1/2 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civilian Gunner		10b. KIND OF BUSINESS OR INDUSTRY Civil Service	
11. BIRTHPLACE (State or foreign country) Havre de Grace, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Steve Singleton(dec)		14. MOTHER'S MAIDEN NAME Priscilla Sampson(dec)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes.		16. SOCIAL SECURITY NO. 220-22-0987	
17. INFORMANT Mrs. Elsie S. Singleton		18. ADDRESS 655 Bourbon St., Havre de Grace, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4-20 1960 to 8-28- 1960 , and that death occurred on 8-28-1960 at 8:25PM from the causes and on the date stated above.			
22a. SIGNATURE E. S. ELLS,		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) E. S. ELLS, M.D., Acting Director		22d. ADDRESS VAH, Perry Point, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 8-28-60	
23c. NAME OF CEMETERY OR CREMATORY Rock Run Cem.		23d. LOCATION (City, town, or county) (State) HARFORD Co. MD	
24. FUNERAL DIRECTOR'S SIGNATURE R. MADISON MITCHELL		25a. REC'D BY REGISTRAR SEP 1 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

100822

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9052
CERTIFICATE OF DEATH

09023
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 30yrs.8mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HOMER Middle L. Last SMITH		4. DATE OF DEATH Month August Day 30 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-14-95
9. AGE (In years lost birthday) yrs. 65		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Phillip Smith		14. MOTHER'S MAIDEN NAME Not available from records	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Nannie Smith, wife, 1621 Dartford Road,		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, bronchial DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction due to coronary occlusion. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2-3 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 31, 1929 , to August 30, 1960 , that I last saw the deceased on August 30, 1960 , and that death occurred at 1:45 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 8-30-60			
ACTUAL SIGNATURE J. L. Garey		M.D. V.A. Hospital, Perry Point, Md.	
PHYSICIAN'S NAME (Type) J. L. GAREY		Clinical Pathologist	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 8/31/1960	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son		ADDRESS Havre de Grace, Md.	
24a. REC'D BY REGISTRAR DATE SEP 7 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09024

Reg. Dist. No.

9039

Item 1 Film 6269 8-25-60 et

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>			c. LENGTH OF STAY IN 1b <u>44 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>												
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>					d. STREET ADDRESS <u>Main St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Milton</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>8</u> Day <u>19</u> Year <u>19 60</u>													
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-12-1882</u>		9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Theater Operator Moving Pictures</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Paw Paw, W. Va.</u>				11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>									
13. FATHER'S NAME <u>Henry Clay Smith</u>						14. MOTHER'S MAIDEN NAME <u>Sarah Frances Amos</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-32-6539</u>				17. INFORMANT <u>Mrs. John M. Smith, North East, Md.</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured skull with injury to Barin and</u> DUE TO (b) <u>contusions of eyes and face and abrasion of knees</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Trying to cross Route 40 and hit by truck</u>													
20c. TIME OF INJURY Month, Day, Year <u>8 17 19 60</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 40</u>				20f. (City or town) <u>North East</u>		(County) <u>Cecil</u>		(State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
ACTUAL SIGNATURE <u>R.C. Dodson</u>				EXAMINER'S NAME (Type) <u>R.C. Dodson</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>8-19-60</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				22b. DATE THEREOF <u>Aug 19-1960</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Silverbrook</u>				22d. LOCATION (City, town, or county) <u>Wilmington, New Castle Del</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u>								ADDRESS <u>North East Md</u>				24a. REC'D BY REGISTRAR <u>DATE AUG 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WESTLAND STATE DEPARTMENT OF HEALTH—MILWAUKEE, WIS.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9053

CERTIFICATE OF DEATH

09025

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 52 S. Carrollton Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First CHARLES Middle H. Last STONE		4. DATE OF DEATH Month August Day 19 Year 19 60				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-18-01	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months 59	IF UNDER 24 HRS. Days 59 Hours 59 Min. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steamfitter		10b. KIND OF BUSINESS OR INDUSTRY Steamfitting		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Halbert L. Stone (deceased)			14. MOTHER'S MAIDEN NAME Daisy Brown (deceased)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 219-07-4312		17. INFORMANT Baltimore, Md. Mary Stone, wife, 52 S. Carrollton Avenue		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate with metastasis to the liver DUE TO the liver Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) 177X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH unknown						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (b) (this hospital) attended the deceased from August 16 1960 to August 19 1960 and that death occurred on August 19 1960 from the causes and on the date stated above.						
22a. SIGNATURE J. L. Garey		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8-19-60		
22c. PHYSICIAN'S NAME (Type) J. L. GAREY		22d. ADDRESS Clinical Pathologist, V.A. Hospital, Perry Point, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/23/60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witzke, Baltimore, Maryland			25a. REC'D BY REGISTRAR DATE AUG 22 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9054
CERTIFICATE OF DEATH

09026

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 18 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 208 Mason Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MAURICE Middle R. Last THOMAS		4. DATE OF DEATH Month 8 Day 27 Year 1960	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-24-10
9. AGE (In years less birthday) 49 yrs.		10. IF UNDER 1 YEAR Months 4 Days 27 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Montgomery County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES THOMAS (DECEASED)		14. MOTHER'S MAIDEN NAME ESTELLE MILLS (DECEASED)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) Yes (If yes, give war or dates of service) WW-11		16. SOCIAL SECURITY NO. 214-18-8237	
17. INFORMANT Mrs. Dorothy L. Carrol-Daughter		Address 204 Martins Lane, Rockville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, left lower lobe DUE TO Carcinoma of the Pharynx with Metastasis to the Pericardium, pleura bilateral, and nodes of the Mediastinum. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) of the Mediastinum. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH Approx. 2 days Unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8-9-60 to 8-27 19 60 XXXXXXXXXX and that death occurred at 3:40am from the causes and on the date stated above.			
22a. SIGNATURE J. L. Garey		22b. DATE SIGNED 8-27-60	
22c. PHYSICIAN'S NAME (Type) J. L. GAREY, M.D.		22d. ADDRESS VAH, PERRY POINT, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-31-60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert Snowden - Rockville, Md.		25a. REC'D BY REGISTRAR SEP 2 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanes			

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DEPT. OF HEALTH

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Department

Health

Room

Rockville

to the

1st floor

See above office

Visiting Assistant Hospital

Ward

Ward

Room

12-1-10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9041

CERTIFICATE OF DEATH

09027
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecil NORTH EAST		c. LENGTH OF STAY IN 1b 11 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LORA Middle COLE Last TYSON		4. DATE OF DEATH Month AUG. Day 17 Year 1960	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/05/1885
9. AGE (In years last birthday) 74		10. IF UNDER 1 YEAR Months 7 Days 17 Hours 17 Min. 17	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) CECIL CO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MARTIN L. THOMPSON		14. MOTHER'S MAIDEN NAME MARY R. WILLIAMS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO If yes, give war or dates of service		16. SOCIAL SECURITY NO. INFORMANT Address CARROLL TYSON NORTH EAST, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pelvic organs and Abdomen DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Ascites DUE TO (c) Cardiac Failure			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 16 , 19 59 , to Aug 17/60 , 19 60 , that I last saw the deceased alive on August 17, 1960 , and that death occurred at 11.22 from the causes and on the date stated above.			
ACTUAL SIGNATURE H. A. Cantwell M.D.		DATE SIGNED North East, Md.	
PHYSICIAN'S NAME (Type) H. A. Cantwell M.D.		22. LOCATION (City, town, or county) (State) North East Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/20/1960	
22c. NAME OF CEMETERY OR CREMATORY HOPE WELL CEM		22d. LOCATION (City, town, or county) (State) PORT DEPOSIT MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Monroe E. McMillen ADDRESS RISING SUN, MD.		24a. REC'D BY REGISTRAR DATE AUG 22 '60	
24b. REGISTRAR'S SIGNATURE Charles S. Kraus			

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Examination of pelvic organs and abdomen

Admission

Obstetric history

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22-10

August 17, 1932

11.23 A

North East Hospital

H. A. Cantwell M.D.

11/10/30

11/10/30

11/10/30

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9055
CERTIFICATE OF DEATH

09028

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point,				c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS Reynolds Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Woodrow Middle W. Last Vickery				4. DATE OF DEATH Month 8 Day 4 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-8-14	
9. AGE (In years last birthday) yrs. 45		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus Driver				10b. KIND OF BUSINESS OR INDUSTRY Bus Company		11. BIRTHPLACE (State or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Walton Vickery				14. MOTHER'S MAIDEN NAME Parlee Reed			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II				16. SOCIAL SECURITY NO. 256-03-7520		17. INFORMANT Address Reynolds Ave Mrs Alton C. Vickery - wife Rising Sun, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO (b) Coronary thrombosis DUE TO (c) Arteriosclerotic heart disease						INTERVAL BETWEEN ONSET AND DEATH 5 days 5 days unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8-1 19 60 , to 8-4 19 60 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8-4 19 60 , and that death occurred at 4:05P from the causes and on the date stated above.							
22a. SIGNATURE Albert L. Mooney				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8-8-60	
22c. PHYSICIAN'S NAME (Type) ALBERT L. MOONEY, Asst. Pathologist				22d. ADDRESS VA Hospital, Perry Point, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 8/9/60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Bennington E. Saxe				ADDRESS Barre de Grace, Md.		25a. REC'D BY REGISTRAR DATE AUG 12 '60	
						25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

08138

CERTIFICATE OF DEATH

3033



MAINTAINED AND DEPARTMENT OF HEALTH
1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]
11. Date of registration: [illegible]
12. Place of registration: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9056 CERTIFICATE OF DEATH

09029

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 139 Thomas St., N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Preston Watson		4. DATE OF DEATH Month 8 Day 7 Year 19 60	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-29-92
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Not ascertainable	
11. BIRTHPLACE (State or foreign country) Newland, Ga.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gus Watson		14. MOTHER'S MAIDEN NAME Lu Collier	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I Not ascertainable	
17. INFORMANT Thomas Watson (B)		139 Thomas St., N.W. Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X Bronchial pneumonia, right lower lobe DUE TO Carcinoma of the lung, right lower lobe. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized severe with aortic thrombosis.		INTERVAL BETWEEN ONSET AND DEATH 4 days Unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 7 - 8 19 60 to 8 - 7 19 60, and that death occurred at 4:10 PM, from the causes and on the date stated above.			
22a. SIGNATURE Albert L. Mooney		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) ALBERT L. MOONEY, M.D., Asst. Pathologist VA Hospital, Perry Point, Md.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 8-11-60	
23c. NAME OF CEMETERY OR CREMATORY ARDINGTON		23d. LOCATION (City, town, or county) (State) ARDINGTON VA.	
24. FUNERAL DIRECTOR'S SIGNATURE Ernest J. Spink		25a. REGISTRAR'S SIGNATURE	
ADDRESS 1432 You St. N.W.		25b. REGISTRAR'S SIGNATURE	
DATE AUG 17 '60			

10000

CERTIFICATE OF DEATH

5058

Gold

Power, John, M.

Residence: 1000 1st St. N. W.

London

1000

10

1000

1000

1000

1000

U.S.

Not a naturalized citizen

1000

1000

1000

1000

Chronological summary of life

Chronology of the last 100 years

Chronological summary, general and severe with medical diagnosis

XXXXXXXXXXXXXXXXXXXXXXXXXXXX

William J. ...

1000 1st St. N. W., London, D.C., ...

1000 1st St. N. W., London, D.C., ...

1000 1st St. N. W., London, D.C., ...

9040

CERTIFICATE OF DEATH

09030

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 369 W. Main St., Elkton				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Elbert Last Wiles				4. DATE OF DEATH Month 8/ Day 22/ Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/13/1889	
9. AGE (In years lost birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 71 Days 0 Hours 0 Min.		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.		12. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) West Jefferson, N.C.	
12. CITIZEN OF WHAT COUNTRY? United States				13. FATHER'S NAME Elbert Wiles			
14. MOTHER'S MAIDEN NAME Flora Sturgill				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. 234-14-3555				17. INFORMANT Florence Lowman			
18. ADDRESS Elkton, Md.				19. ADDRESS Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420. ACUTE CORONARY THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY HEART DISEASE DUE TO (c) ARTERIOSCLEROSIS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumococcal pneumonia							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) pulmonary in emphysema							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 8/21 , 19 60 , to 8/22 , 19 60 , that I last saw the deceased alive on 8/22 , 19 60 , and that death occurred at 7:40 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Peter Stavakis				ADDRESS (Street, city or town, state) Elkton, Md.			
PHYSICIAN'S NAME (Type) Peter Stavakis				DATE SIGNED 8/23/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 8-25-60			
22c. NAME OF CEMETERY OR CREMATORY Matt Mullins				22d. LOCATION (City, town, or county) (State) Beartown, W. Va.			
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME				24a. REC'D BY REGISTRAR DATE AUG 25 '60			
ADDRESS Elkton, Md.				24b. REGISTRAR'S SIGNATURE John S. Kline			

